Appendix D
Prior Authorization

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Introduction

Prior authorization (PA) is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require PA and some may begin prior to requesting authorization.

Purpose of Prior Authorization

The purpose of prior authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Prior authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Prior authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Prior authorization is performed by DMAS or by a contracted entity.

General Information Regarding Prior Authorization

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for PA requests.

The PA entity will approve, pend, reject, or deny all completed PA requests. Requests that are pended or denied for not meeting medical criteria are automatically sent to medical staff for review. When a final disposition is reached the individual and the provider is notified in writing of the status of the request. If the decision is to deny, reduce, terminate, delay, or suspend a covered service, written notice will identify the recipient's right to appeal the denial, in accordance with 42 CFR §200 *et seq* and 12 VAC 30-110 *et seq*. The provider also has the right to appeal adverse decisions to the Department.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care program, the PA entity is able to receive monthly information from and provide monthly information to the Medicaid managed care organizations (MCO) or their subcontractors on services previously authorized. The PA entity will honor the Medicaid MCO prior authorization for services and have system capabilities to accept PAs from the Medicaid MCOs.

Communication

Provider manuals are posted on the DMAS and contractor's websites. The contractor's website outlines the services that require PA, workflow processes, criterion utilized to make decisions, contact names and phone numbers within their organization, information on grievance and appeal processes and questions and answers to frequently asked questions.

The PA entity provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the PA process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the manual.

The MMIS generates letters to providers, case managers, and enrolled individuals depending on the final determination. The following chart shows the entity that receives letters generated from MMIS:

	Provider	**Enrolled Individual**	**Comments**
Approval	X	X	
Denial/Partial Denial	X	X	Appeal Rights are included in all denials/partial denials
Pends	X	X	Applies to DMAS generated PAs
Rejects	X	X	Applies to DMAS generated PAs

DMAS will not reimburse providers for dates of service prior to the date identified on the notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individuals file, and are subject to review during Quality Management Review (QMR).

Except when Medicare is the primary payor, when more that five visits are medically necessary, the provider must request Prior Authorization. When a recipient has Medicare Part B coverage, Prior Authorization is not required. If Medicare denies the claim, the provider may request authorization as a retrospective review. This is the only time that a retrospective review is allowed, and it must be done within 30 days of the notification of the Medicare denial.

The purpose of Prior Authorization (PA) is to validate that the service being requested is medically necessary and meets DMAS criteria for reimbursement. Prior Authorization does not automatically guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the recipient's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.

Prior Authorizations are specific to a recipient, a provider, a service code, an established quantity of units, and for specific dates of service. If Prior Authorization is required, Prior Authorization must be obtained regardless of whether or not Medicaid is the primary payor, except for Medicare crossover claims. The DMAS PA contractor will not accept reviews for recipients who

have Medicare Part A. If Medicare denies the requested stay, the provider may submit a Prior Authorization request for retrospective review, along with the explanation of benefits (EOB) of denial. This request must be submitted to the DMAS PA contractor within 30 days of the Medicare denial.

PRIOR AUTHORIZATION WAIVER SERVICES:

Depending on the PA entity, processes may vary slightly for requesting PA. Please reference the chart at the end of this Appendix for detailed instructions. (Exhibit 1)

PRIOR AUTHORIZATION OF TECH WAIVER SERVICES:

Depending on the PA entity, processes may vary slightly for requesting PA.

Referrals to be screened for the TW are received at DMAS through the Waiver Services Unit. Screening processes for enrollment and clinical criteria for the TW are described in detail in Chapter IV.

Upon meeting clinical criteria and Medicaid eligibility, DMAS enrolls the individual in the waiver. Each individual on the waiver must have a case manager (CM) from DMAS. The CM schedules a home visit to assess the individual's needs and secures a private duty nursing agency. Once PDN is secured, the CM coordinates the start of care and informs the provider of the number of hours needed per week for PDN. The CM authorizes PDN based on the findings of the home assessment, and 360 hours of respite services for each individual. Needs for additional services are determined upon home visits and phone contacts with the CM.

Once DMAS enrolls the individual in the TW and authorizes PDN and respite, the contractor may begin receiving requests for environmental modifications and assistive technology. Since most individuals enrolled in the TW have many needs related to DME, providers may contact the contractor for DME and medical supply needs which are covered under Medicaid's State Plan Option. The contractor will accept requests via direct data entry (DDE), by facsimile, phone, or US Mail. The preferred method is through DDE for a quicker response. The contractor has one business day to process requests from the date the request is received. Specific information regarding the methods of submission may be found at the contractor's website, dmas.kepro.org. The program will take you through the steps needed to receive approval for service requests.

They may also be reached by phone at:

Telephone: 1-888-VAPAUTH
1-888-827-2884

Fax: 1-877OKBYFAX
1-877-652-9329

The chart labeled Exhibit 2 shows the information necessary to process service requests. Pertinent information will be required to process the request. Upon QMR of the provider, the information must be present in the record and fully completed. These documents will be compared against the information submitted to the contractor.

For Durable Medical Equipment (DME) and Supplies, the DMAS PA contractor utilizes InterQual Criteria as a guideline for determining medical necessity. Requests for Prior Authorization will be reviewed by the DMAS PA contractor and a determination made based on InterQual Criteria.

In addition, DMAS requires the following for DME Services:

- The recipient meets InterQual criteria upon admission and continued stay. These criteria may be obtained through:

  McKesson Health Solutions LLC
  275 Grove Street
  Suite 1-110
  Newton, MA 02466-2273
  Telephone: 800-274-8374

  Fax: 617-273-3777
  Website: www.mckesson.com
  or www.interqual.com

The following services will move to the new prior authorization contractor.

HCPCS Code	Procedure Description	Authoring Agency	Notes
S5165	Environmental Modifications Structural Modification	PA Contractor	All EM codes combined cannot exceed $5000 per calendar year
S5165	Environmental Modification Supply Cost Only	PA Contractor	All EM codes combined cannot exceed $5000 per calendar year
S5165	Environmental Modification Transportation Modification	PA Contractor	All EM codes combined cannot exceed $5000 per calendar year
99199 U4	Environmental Modifications Maintenance	PA Contractor	All EM codes combined cannot exceed $5000 per calendar year
S5165	Environmental Modifications Rehab	PA Contractor	All EM codes combined cannot exceed $5000 per calendar year
T1999	Assistive Technology Rehabilitation	PA Contractor	All AT codes combined cannot exceed $5000 per calendar year
T1999	Assistive Technology Off the Shelf item	PA Contractor	All AT codes combined cannot exceed $5000 per calendar year
T1999 U5	Assistive Technology Maintenance Cost	PA Contractor	All AT codes combined cannot exceed $5000 per calendar year

The following services will remain as prior authorization services through the DMAS case managers.

HCPCS Code	Procedure Description	Authoring Agency	Notes
T1002	Skilled Nursing Services, RN	DMAS	As determined by DMAS CM
T1003	Skilled Nursing Services, LPN	DMAS	As determined by DMAS CM
T1019	Personal Care	DMAS	As determined by DMAS CM
T1005	Respite Care, Aide, Per Hour	DMAS	360 hours per calendar year

PRIOR AUTHORIZATION RECONSIDERATIONS and APPEALS PROCESS

Provider Appeals

For Services Prior Authorized by DMAS:
If services are denied by DMAS staff, the provider may request a reconsideration of the denial by writing:

PA Supervisor
Department of Medical Assistance Services
600 East Broad Street, 10th Floor
Richmond, VA 23219

FAX: 1-804-371-4986

For Services Prior Authorized by the PA Contractor:
If services are denied by the preauthorization analyst through the PA Contractor, an automatic reconsideration process will be conducted by a physician reviewer and the provider will be notified of the outcome of the decision.

After completion of the reconsideration process, the denial of Prior Authorization for services not yet rendered may be appealed in writing by the Medicaid recipient within 30 days of the written notification of denial. If the Prior Authorization denial is for a service that has already been rendered, the provider may appeal the denial in writing within 30 days of the written notification of denial of the reconsideration. Written appeals must be addressed to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Recipient Appeals

The provider may not bill the recipient for covered services that have been provided and subsequently denied by DMAS or the PA contractor.

If the denied services have not been provided, the denial may be appealed by the recipient or by the recipient's authorized representative. For additional information on recipient appeals, refer to the appeals section of Chapter IV of this manual.

EXHIBITS

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PRIOR AUTHORIZATION WAIVER SERVICES:

Exhibit 1: This chart details the prior authorization requirements for waiver services.

Waiver Services	AIDS Waiver	DD Waiver	EDCD Waiver	MR Waiver*	Tech Assisted Waiver	Day Support Waiver*	Alzheimer's Waiver	PA Entity*	Requires PA	Retroactive Authorization
Adult Companion Care – Agency		X		X				Contractor	Yes	Yes
Adult Companion Care – Consumer Directed		X		X				Contractor	Yes	Yes
Adult Day Health Care			X					Contractor	Yes	See Ch IV
Assisted Living							X	DMAS	No	No
Assistive Technology		X		X	X			Contractor	Yes	No
Congregate Residential				X				*	Yes	No
Environmental Mods		X		X	X			Contractor	Yes	No
Case Management	X							Contractor	Yes	See Ch IV
Crisis Stabilization		X		X				Contractor	Yes	See Ch IV
Day Support Regular		X		X		X		Contractor	Yes	No
Day Support High Intensity		X		X		X		Contractor	Yes	No
Family/Caregiver Training		X						Contractor	Yes	No
In-Home Residential		X		X				Contractor	Yes	No
Enteral Nutrition	X							Contractor	Yes	No
Personal Care – Agency	X	X	X	X	X			Contractor; Tech Waiver by DMAS	Yes	Yes
Personal Care – Consumer Directed	X	X	X	X				Contractor	Yes	Yes
PERS		X	X	X				Contractor	Yes	No
Private Duty Nursing-RN	X				X			AIDS Waiver by Contractor: Tech Waiver by DMAS	Yes	AIDS Waiver – No; Tech Waiver - Yes
Private Duty Nursing-LPN	X				X			AIDS Waiver	Yes	AIDS Waiver – No;

								by Contractor; Tech Waiver by DMAS		Tech Waiver - Yes
Respite Care - Agency	X	X	X	X	X			Contractor; Tech Waiver by DMAS	Yes	Yes
Respite Care - Consumer Directed	X	X	X	X				Contractor	Yes	Yes
Skilled Nursing –RN		X		X				Contractor	Yes	No
Skilled Nursing - LPN		X		X				Contractor	Yes	No
Supported Employment-Individual		X		X				Contractor	Yes	No
Supported Employment – Enclave		X		X				Contractor	Yes	No
Therapeutic Consultation		X		X				Contractor	Yes	No
Prevocational Services (all)		X		X		X		Contractor	Yes	No
PERS RN		X		X				Contractor	Yes	No
PERS LPN		X		X				Contractor	Yes	No
Crisis Supervision		X		X				Contractor	Yes	See Ch IV
PERS Installation		X		X				Contractor	Yes	No
Service Facilitation Visits (all)	X	X	X	X				N/A	No	Yes

All Waiver Services requested under the Mental Retardation Waiver and the Day Support Waiver are processed through DMHMRSAS.
****Enrollments to the DD, Tech, and Alzheimer's Waivers are performed by DMAS.***
*****Once the individual is successfully enrolled by DMAS in the DD and Tech Waivers, the service requests are processed through the contractor.***
Contractor = KePRO

QUALITY MANAGEMENT REVIEW REQUIREMENTS

Exhibit 2: This chart documents the quality management review requirements for waiver services.

HCPCS code	Description	PA Required	PA Units Requested	PA Units Approved	Service limits	Units	Forms currently submitted for authorization
H2011	Crisis Stabilization- Intervention	Y	Week	Hr/2Wks	60 Day	N/A	Assessment-Documentation done within 72 hours or 457
H0040	Crisis Stabilization - Supervision	Y	Week	Hr/2Wks	60 day	N/A	DMAS 457
H2014	In-home Residential Support	Y	Week	Month	None	Monthly	DMAS 457 & schedule
H2023	Supported Employment - Individual	Y	Week	Month	40 Hrs/Wk--- 780 units / Year	Hour	DMAS 457 & schedule
H2024	Supported Employment - Enclave	Y	Week	Month			
H2025	Pre-Vocational Services, Regular Intensity	Y	Week	Month			DMAS 457 & schedule
H2025 U1	Pre-Vocational Services, High Intensity	Y	Week	Month			DMAS 457 & schedule
97537	Day Support, Regular, Center Based	Y	Week	Month	**	Month	DMAS 457 & schedule
97537 U1	Day Support - High Intensity Center Based	Y	Week*	Month			
97537	Day Support - Regular, Non-Center Based	Y	Week*	Month			
97537 U1	Day Support, High Intensity, Non-Center Based	Y	Week*	Month			
97139	Therapeutic Consultation	Y	Week	Month	None	Hour	DMAS 457, TC plan for increases
99199 U4	Environmental Modifications - Maintenance	Y	1	1	Together cannot exceed $5,000 per Plan year	Units = 1	Description of item requested and actual cost to provider (this is provided to the Case Manager from the provider); evaluation from appropriate professional & provider invoice at PA with actual cost. 30% to invoice actual cost. Always want wholesale cost.
S5165	Environmental Modifications- Rehab	Y	1	1			
S5165	Environmental Modifications - Structural Modification	Y	1	1			

S5165	Environmental Modification - Supply Cost Only	Y	1	1			
S5165	Environmental Modification – Transportation Modification	Y	1	1			
T1999	Assistive Technology Rehabilitation	Y	1	1	Together cannot exceed $5,000.00 per year		
T1999	Assistive Technology Off shelf item	Y	1	1			
T1999 U5	Assistive Technology Maintenance Cost	Y	1	1			
T1002	Skilled Nursing Services, RN	Y	Week	Week	No Limits		CMS 485 Nursing plan of care (Q6Mths)
T1003	Skilled Nursing Services, LPN	Y	Week	Week	No Limits		CMS 485 Nursing plan of care
T1019	Personal Care	Y	Week	Month	**	Hour	DMAS-97A/B, DMAS 99
H2000	Personal care attendant Care - Initial Comprehensive Visit	N	N/A	N/A	1/6 Months		N/A
S5109	Personal care attendant Care - Consumer Training	N	N/A	N/A	1/6 Months		N/A
99509	Routine Visit	N	N/A	N/A	1/30 Days		N/A
99199 U1	Criminal Record Check	N	N/A	N/A	6/6 Months		N/A
T1028	Reassessment Visit	N	N/A	N/A	2/6 Months		N/A
S5116	Management Training	N	N/A	N/A	4/6 Months		N/A
99080	Fiscal Admin Cost	N	N/A	N/A	No Limits		N/A
99199	CPS Registry Check	N	N/A	N/A	No Limits		N/A
T1005	Respite Care Services, Aide, Hour	Y	Week	720	720 Hrs/Calendar Yr		DMAS- 97A/B, DMAS 99, for DMHMR providers 457 and schedule
S5150	CD- Respite	Y	Week	720	720 Hrs/Calendar Yr		DMAS 97AB, 99AB
H2000	CD- Respite Comp Visit	N	N/A	N/A	1/6 Months		N/A
S5109	CD- Respite Consumer Training	N	N/A	N/A	1/6 Months		N/A
99509	CD- Respite Routine Visit	N	N/A	N/A	1/30 Days		N/A
T1028	CD- Respite Reassessment Visit	N	N/A	N/A	2/6 Months		N/A
99080	CD- Respite Fiscal Agent	N	N/A	N/A	No Limits		N/A
S5136	CD-Companion Care	Y					
S5135	Companion Care	Y	Week	Month	744 Hrs/Mo		DMAS-457, 97A/B if you can ask for a schedule.

S5160	PERS Installation	Y	Visit	1/6 Mo	1/6 Months		DMAS 457
S5160 U1	PERS and Medication Installation	Y	Visit	1/6 Mo	1/6 Months		DMAS 457
S5161	PERS Monitoring	Y	Visit/Mo	1/Mo	1/30 Days		DMAS 457
S5185	PERS and Medication Monitoring	Y	Visit/Mo	1/Mo	1/30 Days		DMAS 457
H2021 TD	PERS Nursing - RN	Y	Visit/2 Wks	1/2Wks	1/14 Days		DMAS 457
H2021 TE	PERS Nursing - LPN	Y	Visit/2 Wks	1/2 Wks	1/14 Days		DMAS 457
S5111	Family Caregiver Training	Y	Year	Year	80 Hrs/365 Days		DMAS 457- provider

** All forms are located on the DMAS web site at www.dmas.virginia.gov.*